Patient Name:
Date of Birth:
Medical Record #:
Referring Physician:

SAFETY CHECKLIST

CONTRAINDICATIONS

	YES	NO	IF YES, PLEASE EXPLAIN
Cardiac Pacemaker/Defibrillator	____	____	_____
Prosthetic Heart Valve	____	____	_____
Any Artificial Prosthetic	____	____	_____
Metal in Eyes	____	____	_____
Metal Shrapnel or Fragments	____	____	_____
Programmable Brain Shunt	____	____	_____
Stapedectomy or Cochlear Implant	____	____	_____
Intracranial/Surgical Aneurysm Clips	____	____	_____
Brain Aneurysm Surgery	____	____	_____
If YES, Clips/Coils/Other (Please Explain)	____	____	_____
Neuro Stimulator	____	____	_____
Electronic Implants, Stimulators or Pumps	____	____	_____
Permanent Eyeliner, Tattoos or Piercings	____	____	_____
Stents	____	____	_____
Penile Implant	____	____	_____
IUD (Intrauterine Device)/Pessary	____	____	_____
Pregnant	____	____	_____
Transdermal Patch	____	____	_____
Hearing Aids, Dentures	____	____	_____
Any type of Implant (i.e. Wires)	____	____	_____
Tissue Expander (Breast)	____	____	_____

WITH IV CONTRAST/GAD

Allergy to Latex	____	____	_____
Breast Feeding	____	____	_____
History of Kidney Disease/Dialysis	____	____	_____
Sickle Cell Anemia	____	____	_____
Diabetic	____	____	_____
Respiratory Disease	____	____	_____

ARTHROGRAM ONLY

Allergy to Contrast (CT, MRI or X-ray), Iodine, Betadine or Shellfish	____	____	_____
Blood Thinner Medications (including aspirin)	____	____	_____
Allergy to Latex or Adhesive Tape	____	____	_____

*****EVERYONE IN THE MAGNET ROOM DURING IMAGING MUST WEAR EAR PLUGS*****

Signature _____ **Date Signed:** _____

Witness: _____ **Date Signed:** _____